

# NAVY MEDICINE

November-December 1997



The  
Hospital  
Corpsman  
Who  
Raised  
the Flag

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**COVER:** The Treasury Department used Joe Rosenthal's immortal photograph of the Iwo Jima flag raising for its 7th War Loan poster in 1945. Over his image, PhM2c John Bradley autographed this original print, recently discovered in the BUMED Archives. Story on page 9.

# Fleet Marine Force Medical in Mission Other Than War:

## Operation Pacific Haven

In March 1995, the Pentagon published its revised statement of the United States military strategy to affirm the importance of the growing use of U.S. Forces in global peace-keeping and other noncombat operations. This revised National Security Strategy marks the first time the document had ever emphasized peace-keeping. Recognizing that future military operations will include such nontactical roles as humanitarian and refugee assistance, disaster relief, the building of basic services and medical support, the military services have begun the process of redefining mission support and capabilities to accommodate this expanded role. The role of the medical components for the Navy, Army, and Air Force has grown significantly in responding to major humanitarian and relief missions. Operation Provide Comfort provided support to Kurds in northern Iraq, Operation Provide Promise in the former Republic of Yugoslavia included direct medical support to United Nations Protection Forces prior to NATO assuming the theater mission, and Operation Sea Signal in Guantanamo Bay, Cuba, included medical support for Cuban and Haitian refugees. In

these operations the Medical Departments of the military services relied on variations of echelon III medical delivery platforms to provide care. These platforms are defined by the services as the Fleet Hospitals of the Navy, the Air Transportable Hospitals from the Air Force, and the Army's Combat Support Hospitals.

During Operation Pacific Haven, the Fleet Marine Force (FMF) was assigned responsibility for the first time with providing large-scale humanitarian and medical support services. Elements of 3rd Medical Battalion and 3rd Dental Battalion were task organized to provide health services and screening for the processing of Kurdish refugees. Medical Battalion, the FMF's largest health care delivery platform, has a primary mission to provide direct and general medical support to the expeditionary forces in order to sustain the combat operations. However, during Pacific Haven, the Medical Battalion was called upon to provide services not usually associated with its combat or garrison support mission. In providing care to geriatric, pediatric, and obstetrical Kurdish patients, the Medical Battalion demonstrated its flexibility

and proved more than capable in supporting operations other than war.

### Operation Pacific Haven

Following the Persian Gulf War, the Kurdish population residing in Iraq was forced into northern Iraq in order to avoid persecution by the Iraqi military. They settled into an area that was deemed a "Safe Haven" by the international community. Many of these individuals had assisted the United States in some form or other during and after the war. Due to the service of these individuals and the deplorable living conditions in the "Safe Haven," the decision was made to transit these individuals to the United States and provide them with asylum.

On the morning of 2 Dec 1996, the advanced party of the Marine Forces (MARFOR) component of the Joint Task Force (JTF), Operation Pacific Haven (OPH) deployed to Guam in support of the Kurdish evacuee resettlement from northern Iraq to the United States via Turkey and Guam. The main body quickly followed on 4 Dec bringing the total MARFOR component to approximately 400 Marines and Sailors. MARFOR utilized the unoccupied Tiyan Housing Area, part

**Right:** Medical Aid Station pharmacy. Staffed by two pharmacy techs, the pharmacy filled over 4,500 prescriptions during Operation Pacific Haven. **Below:** ENS Pierkowski, NC, draws blood from Kurdish evacuee during medical screening.

of the old Naval Air Station, for their operations, and after 5 days establishing the camp, a total of 1,355 evacuees arrived over a 4-day period.

### Initial Phases

Since the mission was tasked to the III Marine Expeditionary Force, the 3rd Medical Battalion was called upon to provide medical support. Although 3rd Medical Battalion is usually tasked with providing echelon II medical support in a combat environment, the battalion responded rapidly and effectively to organize for this operation other than war. The continual training conducted by the two surgical companies of the battalion had conditioned the personnel to be operationally ready to respond to any situation. Upon initial notification of the possible deployment, 3rd Medical Battalion personnel developed the Table of Equipment (T/E) and Table of Organization (T/O), performed the Limited Technical Inspection (LTI) on the equipment and consumable Authorized Medical Allowance Lists (AMALs), and palletized all gear on Air Force pallets within 2 days. The ultimate deployment date did not occur for quite some time, but the medical support section was ready.

The 60-person Medical Section of Combat Service Support Element 37 (CSSE-37) was mainly composed of personnel from 3rd Medical Battalion and other various units in Okinawa, Japan, including 3rd Dental Battalion, 3rd Force Service Support Group, III Marine Expeditionary Force, 1st Marine Air Wing, 3rd Marine Division, and Naval Hospital Okinawa. Eight



individuals were assigned from naval medical treatment facilities in the United States and were deployed to Guam via the Medical Personnel Augmentation System (MPAS). The Medical Section was tasked with providing echelon I medical care to both the MARFOR personnel and the Kurdish evacuees. In addition, the Medical Section was responsible for medically screening all evacuees in accordance with the Department of Immigration and Naturalization Service (INS) guidelines and the U.S. Public Health Service (USPHS) protocols as part of their processing for asylum into the United States.

Although everyone knew they would spend at least Christmas and New Year's away from home and without their loved ones, everyone was extremely motivated and eager to participate in this humanitarian operation. The Sailors from operational units had been well trained to incorporate flexibility into their life, and they realized that it was part of their job to deploy and often at a moment's notice.

From the moment the CSSE-37 arrived in Guam, the medical personnel were hard at work. The initial



emphasis was the establishment of the Medical Aid Station (MAS) which would provide echelon I care with the added capability of laboratory, radiology, and pharmacy services. Within 2 days after arrival in Guam, emergency medical services were up and running. The staff continued to add the finishing touches to the MAS in preparation for the Kurdish evacuees' arrival. Five days into the deployment, the evacuees began to arrive. Medical personnel were stationed at the hangar in order to perform an initial medical evaluation on the evacuees and notify the MAS of their medical condition. This helped alleviate the anxiety of the medical staff concerning the health of the evacuees, and also provided them time to prepare for any situation.



HM3 Blue and HN Asidao check in and obtain vital signs of Kurdish girl at the Medical Aid Station. In the foreground is one of the Joint Volunteer Agency interpreters.

Once the evacuees were settled into their housing, they were given a chance to acclimatize to their new surroundings. During this time the daily census in the MAS was extremely high. Over 80 patients per day were being treated, and at the same time, the staff was putting the final touches on the Medical Screening facilities. As soon as the evacuees had adjusted to their environment, the medical screening was initiated. The screening of the 1,355 Kurds began 10 days into the deployment and was completed in only 10 days.

### Medical Screening

The planning to conduct the medical screening efficiently began prior to deployment from Okinawa. A copy of the INS guidelines was obtained and phone calls placed to determine the required supplies and personnel. Since the Kurdish evacuees had a cultural aversion to male physicians examining female patients, six of the medical

officer billets were filled with females. Once the execution order was given, key medical personnel consulted with personnel from the Air Force's 374th Air Transportable Hospital (ATH) at Andersen South. The Air Force had been participating in Operation Pacific Haven since September and had previously medically screened Kurdish evacuees. Based on this information, the CSSE-37 staff modified the Air Force's process to overcome obstacles and efficiently utilize our spaces and personnel.

The Medical Screening section was operated from both three-bedroom units of a military housing duplex which required modification in order to facilitate the efficient processing of the evacuees. Additional fluorescent lighting was installed in each room of the duplex including the living/dining rooms. The three bedrooms used for physical exams were divided in half using shower curtains hung on a steel cable. Wall-mounted, chest X-ray

stands, used to facilitate the production of proper chest X-rays, were installed in two bedrooms. Kitchen cabinet doors were removed in order to provide easy access to laboratory reagents and supplies. And finally, additional phone lines were installed for effective communication and modem access to the Composite Health Care System (CHCS) at U.S. Naval Hospital Guam.

The first step of medical screening was inprocessing and was situated in the living/dining room of one of the duplex units. Evacuees were given at least 36 hours prior notification of their appointments and told to report to in-processing. In order to reduce the evacuees' anxiety levels, all appointments were for family groups instead of individuals, and families were not split during their screenings. Prior to the arrival of the family groups, the staff developed screening records which included all required forms and a checklist of items required for completion. Demographic information was filled in on the forms as much as possible in order to save time during the actual screening. These records would follow the evacuees through each phase of screening and were completed during each phase in order to eliminate the need for transcription. Once the evacuees arrived at inprocessing, their records were pulled and verified with their identification cards, and the evacuees were escorted to the next phase, the physical exam.

The physical exam step utilized the three bedrooms in the same unit as inprocessing. As mentioned earlier, the rooms were divided by shower curtains hung on steel cable which al-

An exam room at the Medical Aid Station which also functioned as the emergency treatment area.

lowed the medical officers to screen an entire family at once (men on one side and women on the other). Again this served to keep the families together and reduce their anxiety. The history and physical examination were completed according to INS specifications with particular emphasis on the diagnosis of infectious disease. In order to overcome the language barrier, interpreters were utilized when necessary. Once the exam was over, which was usually completed in 15 minutes, the evacuees were escorted to the other unit of the duplex to complete the screening process.

The next step was immunizations and phlebotomy which was placed at this point in the process to provide adequate time after immunizations to monitor for any allergic reactions. All evacuees 15 years or older had blood

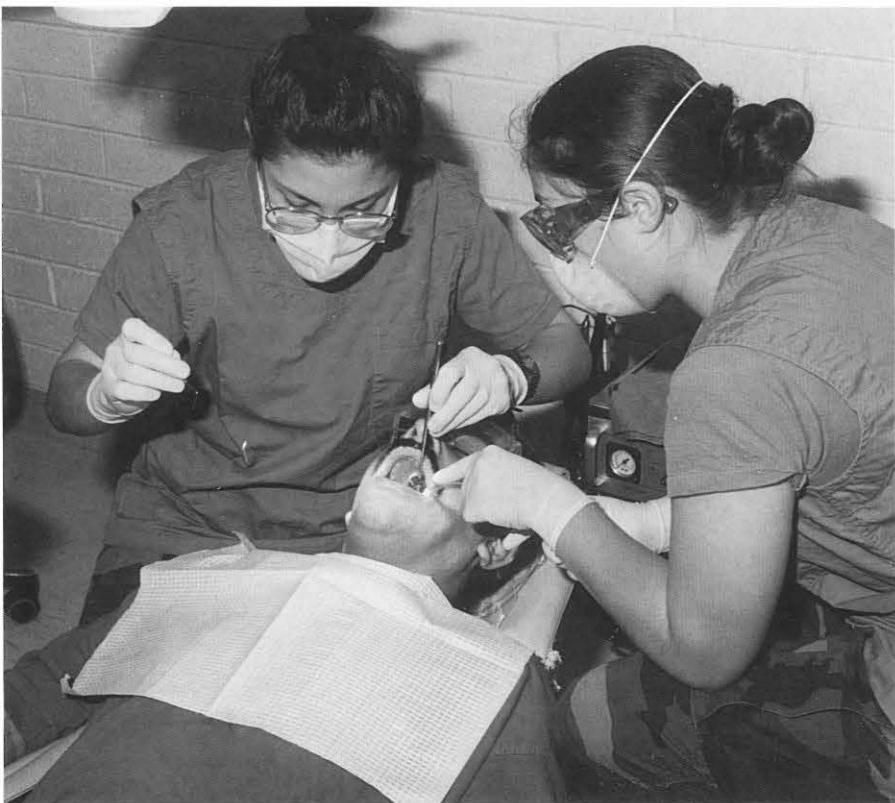


samples drawn in order to test for the human immunodeficiency virus (HIV) and syphilis. The syphilis test was completed in our deployable laboratory, but the HIV test was sent to the U.S. Naval Hospital Guam for testing. Children ages 1 month to 1

year were given oral polio (OPV) and diphtheria/pertussis/tetanus (DPT). Children ages 1 year to 7 years were given OPV, DPT, and measles/mumps/rubella (MMR). Adults and ages seven and older were given diphtheria/tetanus (DT). Of all the steps in



Combat Service Support Element-37, Medical Section personnel and translators pose with MGGEN Rollings, Commanding General III MEF, outside the Medical Aid Station during his tour of Camp Tiyan.



LT Hartzell, DC, and DT3 Rodgers provide dental treatment to a Kurdish evacuee.

noninfectious TB, no cases of syphilis, and no positive HIV tests.

The screening process was developed to be as efficient as possible in order to reduce the time the evacuees were required to spend in screening and to facilitate the rapid completion of 1,355 evacuee screenings. Through long hours and the extremely hard work of the Medical Section staff, all the evacuee screenings were completed in a 10-day period. At the completion of the screening, approximately half the medical staff redeployed to their parent battalions or commands while the remainder of the staff continued to provide medical services to the evacuees until their departure to the United States.

### Successful Mission

Although the deployment was long, the entire Medical Section was proud to have participated in this highly successful operation and to have assisted the Kurdish evacuees during their resettlement process. The Fleet Marine Force medical and dental organization proved itself more than capable of successfully managing humanitarian missions and operations other than war. The main reason behind the success of this operation was the exceptional performance of the highly motivated medical and dental personnel who are operationally focused and trained to remain flexible in any situation and to respond appropriately. □

—Story by LT Tracy T. Skipton, MSC, USNR, Commanding Officer of the Medical Section, Combat Service Support Element-37, Marine Forces Component, Joint Task Force, Operation Pacific Haven, Guam, from 2 Dec 1996 to 20 Mar 1997. Currently LT Skipton is the Commanding Officer, Headquarters and Services Company, 3rd Medical Battalion, 3rd Force Service Support Group, Okinawa, Japan.

the screening process, immunizations and phlebotomy caused the most distress due to the involvement of needles. The evacuee interpreters utilized in this section did a wonderful job keeping the children as calm as possible.

Radiology was the next stop where all evacuees ages 15 or older were required to have a chest X-ray completed. Based on the site visit to the ATH at Andersen South, it was obvious that radiology was the slowest step in the process. In order to alleviate the possible bottleneck, X-ray machines were set up in two different bedrooms. One bedroom, which had a large walk-in closet (utilized for a changing room), was for females, and the other bedroom was for males. Since the evacuees were even averse to having a male take a female's X-ray, two female corpsmen were trained to assist. Joint Volunteer Agency (JVA) interpreters were utilized to explain the process to the evacuees and give them instructions. The X-

rays were then immediately read by the radiologist, who utilized a closet for his work center, in case additional X-rays were required. Any abnormalities, especially any consistent with tuberculosis, were annotated on the INS medical screening form by the radiologist. The family group was then escorted to the final screening station.

The final screening step was outprocessing. The staff in this phase reviewed the family group's screening records to verify that all required processes were completed and documented. At this point, the evacuees had completed their portion of the screening which took approximately 2 to 3 hours. The outprocessing staff maintained the records until all lab results were completed and documented. The records were then reviewed by medical officers to determine if any conditions existed that might preclude an evacuee's asylum into the United States. Screening 1,355 evacuees, there was only one case of

# The Power of Networking: A Special Message to Colleagues Within Navy Medicine

LT Ron Gimbel, MSC, USNR

Every military member who joins Navy medicine has one factor in common with all colleagues—an initial accession date and a separation date. Regardless of specialty, rank, or length of service, one morning you will wake up and realize that you will not be wearing a uniform to work. How prepared are you to handle the transition to the private sector? Who can you call to provide guidance or encouragement? When should you start preparing for this transition? Each of these questions will be addressed within this article which is adapted from a best-selling networking book by Fisher and Vilas entitled "*Power Networking: 55 Secrets for Personal & Professional Success.*"

## Networking Defined

When discussing the concept of networking with colleagues, I have observed that many people truly do not understand the concept. According to Fisher and Vilas, "...networking is an approach that encompasses all areas of life, generates fulfillment and satisfaction at a deep level, and links people together for a surge of productive activity...not defined by how much is gained from others, but rather by the human interaction and the

personal value generated by the interaction."<sup>(1)</sup> The concept is based on three P's: power, people, and promotion. Related to the definition of networking is a description of what networking is not. Networking is not selling, is not using people strictly for your gain, is not coercing someone to do what you want, is not putting colleagues and friends on the spot, nor badgering people.<sup>(2)</sup>

## Why Network?

Whether you are preparing to separate from Navy medicine, or anticipate 10 years or more of additional active service you probably have established both professional and personal goals. Networking can be the mechanism that facilitates your efficient accomplishment of these goals. While Navy medicine maintains superb career opportunities, a 20- or 30-year career is no longer a "guarantee." I have a good friend who is a physician-specialist who was asked to retire earlier than he expected. Although he is a superb clinician, he did not realize the power or importance of networking. As a result, it took him approximately 7 months after separation to penetrate the job market within his specialty in a desired location. Consider the implications of these basic statistics:

- Approximately 70 percent of all jobs are found through networking.
- Most people you meet have at least 250 contacts.
- Anyone you might want to meet or contact is only four to five people away from you.(3)

In addition to preparing for future employment, networking can have immediate implications for application within our health system. Whether you are a provider who just diagnosed a rare disease, an administrator tasked with developing a new managed care program, or a corpsman informed that your unit is mobilizing within 48 hours, a developed network can improve your ability to perform your duties and conquer difficult tasks.

## **Twelve Ideas to Get Started**

While there are literally hundreds of tips and recommendations available for those desiring to start or refine their personal network, here are 12 ideas to get started:

**● Know the Important Values and Principles in Your Life.** The first step in becoming a powerful net-worker is to get your own life in order and orient your life around the values and principles that are important to you. When you are aware of your top values (not the values that you think you should have), you will possess a more solid foundation from which to relate yourself and others.

**● Give Up the Lone Ranger Mentality.** Many individuals grow up hearing the phrase “If you want a job done right, do it yourself.” This phrase represents the attitude dubbed the “Lone Ranger Mentality.” This mentality exemplifies the belief that we must know it all, do it the best, not show any weakness, and not let anyone know when we need help. It is also a major stumbling block to effective networking.

**● Focus on People as They Are Introduced to You So You Can Remember Their Name and Who**

**They Are.** The key aspects of memory recall are focus, association, and repetition. You must be interested in people and realize the value of remembering them in order to be effective with memory recall. People like to be remembered, and one of the highest compliments you can pay anyone is to listen and remember his/her name. Consider this statement, “People don’t always care how much you know, but they know how much you care by the way you listen.”

**● Become Comfortable Playing Host at Networking Events.** Networking events can be loosely defined as any gathering which provides you the opportunity to meet with other people you may or may not know socially or professionally. This could include professional development conferences, professional organization meetings, chamber of commerce events, health-related organization fund-raisers, command picnics/social events, and alumni events or parties, to name just a few. Consider volunteering to act as host for an upcoming event. There are several benefits of acting as host which include: being the catalyst who helps others interact, reinforcing individuals names into your memory, experiencing more ease and comfort yourself, and finally, presenting a visible positive image for yourself.

**● Be Gracious and Courteous With Everyone You Meet.** Hectic lifestyles sometimes cause us to overlook common courtesy and good manners. Since networking is about people and relationships, it is important to make sure that the use of courtesy and good manners is a priority.

**● Acknowledge the People Who Inspire You Whether or Not You Personally Know Them.** Do not assume that people already receive a lot of praise and positive reinforcement. Most people mean well, but tend to forget to pass along those words of praise or encouragement. I have observed how this concept benefited an administrator who ultimately entered into a protege/

mentorship relationship which stemmed from an initial letter.

**● Graciously Receive and Accept Acknowledgment and Support.** Rejecting the praise of others is often received as offensive and insulting. If you are the type of individual who is embarrassed when receiving praise, get over it! At a minimum, an appropriate response should be a simple “thank you.”

**● Consistently Find Opportunities to Ask, “Who Do You Know Who . . .?”** When asking for contacts, it is important to word your request to generate the best response. The question, “Who do you know who . . .?” makes people begin to think about who they know, which creates a greater possibility for a response.

**● Serve on a Committee, Board, or Other Leadership Position of a Professional or Health-Related Organization.** As a committee or board member, you create visibility for yourself while gaining new stature as a participant, contributor, and leader. You will broaden your own horizons and expand your experience as a leader and networker. It also provides a solid platform for you to help others and make a difference.

**● Regularly Give Referrals to and Make Requests of Your Network.** Being a networker means being responsive to the people and circumstances around you. You can nurture and reinforce your network consistently with support. Look for opportunities, train yourself to pay attention, listen to what people are saying, and find out how to be of service.

**● Be Aware of and Use the “3-Foot Rule.”** The “3-foot rule” states that anyone who is within 3 feet of you is a potential candidate for conversation and networking. When I observe professional functions which are attended by both professionals from the private sector and those employed in Navy medicine, I most commonly notice a

definitive segregation of the audience into several homogeneous groups. I recommend that you get out of your “comfort zone” and attempt to meet new people. From a personal experience, my best application of this concept happens during airline travel. The person sitting next to you on the airline is a captive audience, usually somewhat affluent (to afford airline travel) or at least interesting. During the past 3 years I have met several CEOs, a semi-professional football coach, a partner in a large accounting firm, and numerous physician and health professional contacts. This type of networking approach can be good practice for a beginner in the field.

**● Approach Each Contact and Opportunity With an Open Mind.** You cannot know with certainty what the end result will be when you make a contact or approach a new situation. Your willingness to approach people with an open mind will increase your chances of generating new opportunities through networking.(4)

## Summary

The 12 ideas identified within this article are not meant to be an all-encompassing equation for success, but can launch you toward developing an effective network. To be successful in networking you must be willing to handle some degree of risk, be willing to step outside your self-imposed comfort zone, be genuinely interested in helping others, and be willing to accept feedback. Why not look at the world as one big network and get started today!

## References

1. Fisher D, Vilas S. *Power Networking: 55 Secrets for Personal and Professional Success*. Austin, TX: Mountain Harbor Publications; 1992: 39-41.
2. Ibid., p 22.
3. Ibid., p 16.
4. Ibid., pp 59-161.

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# The Hospital Corpsman in World War II's Most Famous Image

HMCS(FMF) Mark T. Hacala, USNR

**A**ssociated Press photographer Joe Rosenthal snapped what is perhaps the most famous photograph of all time. The image of Marines laboring to raise the U.S. flag on Iwo Jima's Mount Suribachi has become a symbol of dedication in the face of adversity.

Ironically, in this most famous of Marine Corps images, the only visible face is that of a Sailor, a Navy hospital corpsman.

Pharmacist's Mate Second Class John H. Bradley, the second figure from the right on the near side of the photo, joined with five Marines to raise Old Glory on 23 Feb 1945. This second flag raising (a smaller flag was raised earlier) would be used on a postage stamp, on several posters for the 7th War Loan bond drive, and as the basis for Felix de Weldon's statue which forms

the Marine Corps War Memorial in Arlington, VA.

Erecting the flag pole on Mount Suribachi was a minor event in the battle for Iwo Jima. Initial assaults on

the beach had begun on 19 Feb 1945. The Marines seized Suribachi and raised the flag 4 days later, but the battle would rage on until the island was declared secured on 26 Mar.

Even after that, Japanese die-hards continued to harass Americans on the island for months. Seizure of the volcano, then, was only a prelude of bitter struggles to come.

It is the symbolism of that struggle which the Rosenthal photograph depicts. The composition and action captured in the shot inspired the nation because they reflected teamwork, dedication, and effort. Bradley and the two Marines who survived the battle were considered heroes for their effort in raising the flag. Although that act was more

inspiring than heroic, PhM2c John Bradley was, in fact, a hero, one whose



PhM2c John Bradley with RADM William Chambers, NNMC Bethesda, MD, 1945

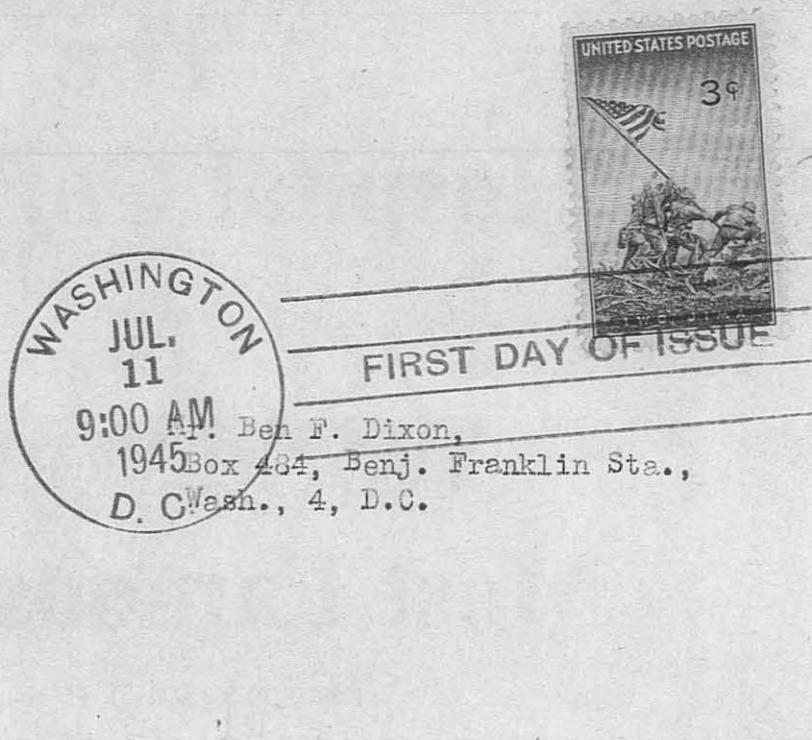
**JOHN BRADLEY, HOSPITAL CORPSMAN HELPED RAISE THE FLAG ON IWO JIMA Stamp**

Photographs of the design adopted for the Iwo Jima commemorative postage stamp to be issued July 11 were released by the Post Office Department yesterday.

The stamp, paying tribute to an outstanding achievement of the marine corps, is based on the photograph made by Joseph Rosenthal, showing the raising of the flag on Mt. Suribachi. It was issued in response to widespread popular demand culminating in a resolution signed by 12 Senators, headed by Senator O'Mahoney (D.) of Wyoming, early last week.



Iwo Jima Stamp



deeds were overshadowed by the luckiest camera shot ever taken.

John Henry Bradley was born in Antigo, WI, on 10 July 1923. He grew up in Appleton, WI, and completed high school there in 1941. Bradley apprenticed as a funeral director after high school and in January 1943 enlisted in the Navy.(1)

Bradley completed boot camp and Hospital Corps School in Farragut, ID, a wartime training center named by President Franklin Roosevelt. After completion of his Hospital Corps training in May 1943, he was assigned to Ward 44A of Naval Hospital Oakland, CA.(2) Upon transfer to the Fleet Marine Force in January 1944, he attended Medical Field Service School. He was then assigned to Company E, 2nd Battalion of the newly-formed 28th Marines in April. The 28th Marines spent the next several months training in small unit tactics, progressing to regimental exercises by July of 1944. The regiment re-

hearsed amphibious assaults on California beaches and then proceeded to Hawaii, where its members practiced combat techniques on ground similar to that they would find on Iwo Jima. By January 1945, Bradley's unit was ready to attempt its objective.(3)

Bradley landed with the 5th Marine Division in the ninth wave on the morning of 19 Feb. "The action was terrific the moment we made the beach," Bradley said. "I was watching Clifford R. Langley, PhM3c, in another landing craft. He made the beach just about 10 seconds before I did, but when I touched sand he was already treating a man."(4)

The 28th Marines immediately set about to take Mount Suribachi. Bitter fighting ensued around the base of the mountain and up the slopes as concealed Japanese defenders made every effort to hamper the Marines. "Progress was slow in the face of fanatical resistance," Bradley would later write. "Concealed Japanese po-

sitions had to be taken by hand-to-hand combat." It was during this combat on 21 Feb that Bradley distinguished himself.

On seeing a wounded Marine, Bradley rushed to his aid through a mortar barrage and heavy machine gun fire. Although other men from his unit were willing to help him with the casualty, Bradley motioned them to stay back. Shielding the Marine with his own body, the hospital corpsman administered a unit of plasma and bandaged his wounds. Through the gunfire, he then pulled the casualty 30 yards to safety.(5)

Two days later, Bradley was with a patrol from his company, which had found a secure path up the mountain. "All the way up I kept wondering, how the devil was I going to get the casualties down off that rock," Bradley recalled. "It was steep and if I had to set up any kind of aid station up there, I'd need supplies. I still don't know how I would have gotten the wounded

**Left: First day cover with new Iwo Jima stamp issued on 11 July 1945.**

down but I'm sure grateful it wasn't necessary."(6)

The first U. S. flag was raised at the summit at about 1020. Because it was deemed too small to see, a larger flag was obtained from *LST* 779 and carried up the mountain. Bradley, seeing that the men with the new flag were having difficulty, jumped in to give them a hand erecting the pole. The first flag was brought down as the second was raised, and it was then that AP photographer Rosenthal clicked his shutter.(7)

"What picture? I didn't know he'd taken our picture," Bradley would later say. "I didn't even know there was a photographer around. I was too busy and too damned grateful for having gotten up that rock alive. Down at the base there wasn't 1 of the 40 of us who expected to make it. We all figured the Japs would open up from the caves all the way up to the crater."

While the film made its way to newspapers around the world, the Marines and Sailors continued the bloody fight with the Japanese. Bradley continued to treat casualties until, on 12 Mar, he took shrapnel in both legs. "I don't remember who treated me right after I was hit. I guess I was a little groggy," Bradley would recount. "But when I started to notice things it seemed like we were back in training only it was my turn to be in the litter."

Bradley made the long trip through the casualty evacuation chain. He was sent first to his battalion aid station, then to the field hospital on Iwo. He was flown to Guam, shipped to Hawaii, and further to Naval Hospital Oakland. Ironically, he ended up in Ward 44A, the site of his first practical experience as a hospital corpsman.(8)

Once it was discovered that Bradley was one of the flag raisers, he went with the other two living participants to Washington. The flag raising image was reproduced on posters for the 7th War Loan drive, and the men traveled around the country making speeches urging Americans to buy bonds. Bradley described the demands of this publicity as "mighty rugged."(9)

In addition to the war loan posters of the Iwo Jima image, the scene was reproduced in countless places. The U. S. Post Office issued a 3 cent stamp of the flag raising on 11 July 1945. With that, John Bradley became the first hospital corpsman and (with the other survivors of the event) one of the first three living people to appear on a U. S. Postage stamp.

John Bradley was medically discharged from the Navy in November 1945. He left the service with the Purple Heart Medal, the Presidential Unit Citation, the Asiatic-Pacific Campaign Medal with star (for Iwo Jima), and the World War II Victory Medal. Although his heroism at the base of Mount Suribachi had been observed, Bradley was not formally recognized for the act. He returned to Wisconsin and settled into his lifelong career as a funeral director.(10)

After the war a Marine Corps officer, David Severance, discovered that Bradley had not received an award for his heroism in treating the casualty on 21 Feb 1945. Severance knew that he had been recommended and resubmitted the award nomination.(11) Although not presented until spring of 1949, the Navy Board of Decorations and Medals approved Bradley's Navy Cross in September 1947.

John Bradley avoided any attention directed to him as a result of his participation in the flag raising. When people called to request interviews, the family was instructed to reply that he was "on a fishing trip in Canada."

Bradley did not fish and had never been to Canada.

Although a hero in his own right, John Bradley continued to mention the team effort of his fellow hospital corpsmen and the Sailors and Marines of the entire task force that took Iwo Jima. "We do not consider ourselves heroes of any sort just because Mr. Joe Rosenthal happened to take a picture."

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# How to Order Prescription Eyewear

HM1 Teresa L. Strebiger, USN

Everyone who has ordered prescription military eyewear has had some difficulty filling out the order form, DD 771. Finding all the necessary information on every SF 600 is rare. This article is designed to help the Independent Duty and General Duty corpsman serving with operational units. More importantly, it will reduce the chance of anyone having the order returned for incomplete information.

**Taking Measurements.** The interpupillary distances (PD), both near and far, are important for all orders. This measurement is where the patient will look through their glasses. If it is incorrect, prism will be induced and the patient will experience visual difficulties.

Obtaining a PD should be done while the patient is seated. At the same eye level and maintaining a distance of about 18 inches away, place a PD ruler (NSN 6540012505737) on the bridge of the patient's nose. Positioning the left index finger directly below your left eye, instruct the patient to look at the tip of your finger. Line up the zero mark of the PD ruler with the inner limbus (where the sclera meets the iris) of the patient's right eye; to do this, you must close your right eye. Now instruct the patient to follow your left index finger as you cross over and reposition your finger below your right eye. Note the PD ruler marking at the outer limbus of the patient's left eye; this is the measurement for the distance PD. For the near PD, open both of your eyes. Instruct the patient to follow your finger to your nose. Without moving the ruler, note the position of the outer limbus of the left eye. This measurement is the near PD.

**Frame Fitting.** Look in the patient's record, or check the patient's current eyewear. Stamped on the frame front, temporally or on the bridge, are two numbers with a

square in between. The first number is the eye size, and the second is the bridge size.

Ask the patient if the frame is comfortable. A good fitting frame should rest comfortably on the nose. Eye size should be large enough that the temples are straight back from the hinges; no impressions should be left on the temples of the patient's face. The top of the frame should be slightly farther away from the face than the bottom of the frame, and should not rock back and forth. If the smallest size is too wide, or it does not rest on the patient's bridge (because the bridge is flat), adjustable nose pads can be ordered.

Standard temple length is 4 1/2 inches (145 mm). There are two sizes printed on the temple; the first is from the hinge to the bend, and the second is from the hinge to the end of the temple. Use the first number when ordering, this will avoid confusion. A proper fitting temple is one that has the bend positioned on the top of the ear, or just slightly behind it. Comfort cables (wrap around ear pieces), may be ordered depending on the patient's preference or work environment.

**Segment Heights.** The last measurement that may be needed is the segment height. Have the patient place the frame on his/her face, and ensure it is level. Have the patient look straight ahead. Using a PD ruler, measure for bifocals from the top of the lower eyelid to the bottom of the frame. For a trifocal, measure from the bottom of the pupil to the bottom of the frame. Be sure to measure for both eyes; segment heights may vary due to placement of frames on the patient's face.

**Ordering.** After all the measurements are taken, the information needs to be transcribed onto the DD 771. It is important to double-check all the information transcribed

before signing the order. This will prevent having the order returned.

**Account Number.** The account number is important for the lab at Yorktown, VA. Since the lab is automated, this number allows tracking of orders, and should be placed above the order number box.

**Date.** This is the date the form was filled out, not the date the prescription was performed.

**Order Number.** This number is for the originating activity to log and track their orders. Any alpha-numeric combination is fine.

**From.** Fill this in completely. Complete information will ensure that finished orders are returned to the proper originator.

**Name, Grade, and Service Number.** The patient's last name, rank, and last four numbers of the social security number are required. This is very important; tracers are based on this information.

**Unit and Address.** Either the member's unit or home address can be used. Additionally, a telephone number should be placed in this space.

**Status.** "Other" is for National Guard and the Reserves.

**Branch.** "Other" is for the Marine Corps.

**Spectacles.** "Male" and "female" are for standard issue S-9 frames only; if "female" is checked, reverify it in the "Special Lenses or Frame" section.

**Aviation Spectacles.** These three boxes are for ordering aviation spectacles only; they are not used for ordering S-9's. "Coated" is no longer used.

**Interpupillary Distance.** When ordering any spectacles, the distance PD is required. Near PD is required for all bifocal, trifocal, and near vision only (NVO). NVO's should not be ordered for aviation spectacles, P-3's, or gas mask inserts.

**Eye Size.** Eye size of frame being ordered.

**Bridge Size.** Bridge size being ordered.

**Temple Length.** Written in either inches (in) or millimeters (mm).

**Number of Pair(s).** The maximum number ordered per DD 771 is two. In addition, order only one type of spectacle per DD 771; separate DD 771's are needed for clears, tints, and gas mask inserts.

## Single Vision

**Sphere.** Expressed in either a positive or negative numerical value of at least three digits (i.e.: +0.25 or -7.75). Opposite sphere signs should be verified in the "Special Lenses or Frame" section.

**Cylinder.** If no cylinder power is prescribed, "sph" is

written in this box. Orders should always be written in minus cylinder; when a prescription is presented in plus cylinder, and you are unsure how to correct it, write it as it is shown on the member's prescription and verify it in the "Special Lenses or Frame" box.

**Axis.** Expressed in a three digit numerical value between 000 and 180. However, if there is no cylinder power, there will not be an axis.

**Decentration In/Out.** Leave blank.

**Prism.** Used only if prism is prescribed for the patient.

**Base.** If there is a prism box entry, the direction must be noted; the direction is either "Up," "Down," "In," or "Out."

## Multivision

**Add for Near.** For use with bifocal or trifocal prescription only. The minimum add power for bifocals is +0.75, and for trifocals is +1.50.

**Segment Height.** When an add power is entered, a segment height must be entered too. For trifocals, "OA" (overall height) is written next to the height; this reminds the originator that the measurement was taken for a trifocal, and not a bifocal. For gas mask inserts, "-3" is written; a standard 3 mm drop is given to all gas mask inserts.

## Special Lenses or Frame

This space is used to verify any nonstandard request, or anything out of the ordinary. They are as follows:

- PDs less than 60 or greater than 70
- Unlike sphere signs, and plus cylinder
- Type of multifocal segment (i.e.: straight top (ST) 28 to 35. The number designates the width of the segment; ST 28 is 28 mm, ST 35 is 35 mm)
- Different or unusual adds or segment heights
- Adjustable nose pads and comfort cables
- Tint type; N15, N31, grey, or pink
- Justification for flight frames and nonstandard frames
- Type of gas mask insert
- Female frames
- NVO

**Special Notes.** When converting a multifocal prescription to a NVO, algebraically combine the "add for near" and the "sphere." Do not change the cylinder power or the axis. Now leave the "add for near" and "segment height" boxes blank. □

# *Shipwreck's* **Go-By:** The Ultimate HM Handbook

LT Frank Carvalho, MSC, USN

LT Carvalho is a physical examination instructor at Surface Warfare Independent Duty Corpsman School, Naval School of Health Sciences, Portsmouth, VA.

**S**o! You've just finished an administrative billet duty station. Your new assignment is under way somewhere on a humanitarian mission. Regardless of your NEC, occasionally you may be tasked with actual sick call provider responsibilities. After all, you are a corpsman, RIGHT? Sometimes, expertise in your specialty rating can really put you behind the eightball. When a shipmate sees the caduceus, he sees a hospital corpsman, not a lab, pharmacy, or X-ray tech. It doesn't matter what rank you are, doing sick call can shake up even the most veteran providers.

I wrote *Shipwreck's Go-By* for all hospital corpsmen. I was a former quad zero, turned lab tech, turned IDC, now

## GASTROINTESTINAL

Inspect abdomen for lesion, masses, distension, erythema, edema, ecchymosis, color changes, striae.

Auscultate all four quadrants for bowel sounds, listen to aorta, renals, iliac arteries.

Palpate (light/deep) for guarding, rigidity, masses, tenderness.

Percuss entire abdomen, liver and spleen.

## PERTINENT POSITIVES AND NEGATIVES

? Masses, aneurysms, bruits

? Hepatosplenomegaly

? Rigidity, guarding, rosings

? Rebound, referred rebound

? Psoas, obturator

? Heelslap, pelvic shake

? Ascites (fluid wave)

? Murphy's, Cullen's, Grey-Turner's sign

## Rectal Exam

? sphincter tone, hemocult

? fissure, fistula, hemorrhoids

? ulceration, excoriation, infection, lesions

? Prostate: size, shape, consistency, boggy, hard, firm, enlarged, nodules, masses, tenderness

physician's assistant. Having been in the situation several times in my 21-year career, I decided to make a handbook that is user-friendly. Too many handbooks are way too involved, complicated, and attempt to fit an entire curriculum into a pocket book. It really can't be done effectively, without turning the handbook into a miniature novel. And who really reads those books anyway?

I decided to get rid of the extra and just include the important details. These are items which should *always* be addressed with the patient, both before and during the examination. Most critical is the documentation of these findings in the patient's record. Another benefit of using *Shipwreck's Go-By* is the issue of presenting a case to a

medical officer; it will remind the HM of the exams he should consider doing beforehand. Realizing that many HM's work directly with an IDC, I organized this booklet in a fashion that can be easily taught over a short period of time. Shown are three sample pages of what's in the handbook.

*Shipwreck's Go-By* has been accepted by SURFLANTMED, SURFPACMED, NUMI SUB-IDC School, SFIDC School, FMF School, and BUMED. The direct download is <http://www-nshspts.med.navy.mil/nshs/sw/index.htm>. The homepage is <http://www-nshspts.med.navy.mil>. So check out the site and download your *Shipwreck's Go-By*, you'll be glad you did! □

## KNEE

Observe patient presentation, consider mechanism of injury. Palpate all landmarks.  
Consider hip, ankle involvement.  
Do neurovascular check (L3, L4, L5, S1, S2).  
Consider Sensory Specific testing.

## PERTINENT POSITIVES AND NEGATIVES

- ? Edema, erythema, ecchymosis, effusion
- ? Deformity, stability, masses, tenderness
- ? Valgus (med collateral)
- ? Varus (lat collateral)
- ? Anterior drawer (anterior cruciate)
- ? Posterior drawer (posterior cruciate)
- ? Lachman's (ACL)
- ? Posterior Sag (PCL)
- ? Apley's compression (meniscus)
- ? Apley's distraction (collaterals)
- ? Flick test, Duckwalk, Childress (meniscus)
- ? McMurray's Bounce home test (meniscus)
- ? Ballotment, bulge sign (effusion)
- ? Patellar grind (PFS, CMP)
- ? Tinel sign (neuromata)
- ? ROM, muscle Strength (active/passive)

## ANKLE/FOOT

Observe patient presentation, consider mechanism of injury (MOI). Palpate all landmarks.  
Consider knee, hip, back involvement. Do neurovascular check (L4, L5, S1).  
Consider Sensory Specific testing.  
Inspect and Palpate all landmarks.

## PERTINENT POSITIVES AND NEGATIVES

- ? Edema, ecchymosis, erythema, effusion
- ? Lesions, rashes, masses, nodules
- ? Deformity, tenderness, crepitus (where?)
- ? Neurovascular (L4, L5, S1), sensory specific
- ? Stability (ATFL, CFL, PTFL, deltoid ligament)
- ? Talar rock, ant drawer
- ? Metatarsal squeeze (morton's neuroma)
- ? Plantar fascia
- ? Peroneus brevis
- ? Fx (Jones, Pott's, Talar dome)
- ? Squeeze test (Achilles)
- ? Syndesmosis disruption
- ? Homan's Test (DVT)
- ? ROM, muscle Strength (active/passive)
- ? Bursitis, (inflammatory, septic)

# Coup in Saigon: A Nurse Remembers

**T**hirty-four years ago the Ngo Dinh Diem regime in South Vietnam fell after a bloody coup. That event could trace its origins to the 1954 defeat of French troops at Dienbienphu and the signing of the Geneva Agreements creating North and South Vietnam. More than 860,000 refugees, almost 500,000 of them Catholics, soon began a mass exodus from North to South Vietnam, bringing with them accounts of communist persecution.

Even though U.S. officials soon became conscious of Ngo Dinh Diem's shortcomings as a leader, the strongman seemed the best hope to hold the line against communism in Southeast Asia.

There was little basis for optimism. Diem surrounded himself with friends and relatives, installing many of them in key government positions. He deposed Emperor Bao Dai, rigged a national referendum, and appointed himself the first president of the Republic of Vietnam.

Most importantly, he failed to hold elections as called for in the Geneva Agreements.

Yet, as the new bulwark against communism, the Diem regime received direct American financial and later military aid. In 1955 Senator Hubert Humphrey characterized Diem as "the leader of his people. He deserves and must have the wholehearted support of the American government and our foreign policy." At that time, such support came from both the Democratic and Republican parties.

There were other complications. Communist Viet Minh guerrillas, later known as the Viet Cong, began a systematic policy of harassment, assassination, and sabotage. Diem responded by beefing up his army and putting social and political reforms on hold. Both the Eisenhower and Kennedy administrations responded to the communist threat by sending military advisors.



Photos courtesy LCDR Bobbi Hovis, NC(Ret)

LCDR Hovis with one of her patients in ICU soon after the hospital commissioning.

*Besides the communist challenge, other strains confronted the new nation; there were pressures from the political and religious opposition that would eventually culminate in the tumultuous overthrow of the regime and Diem's own violent death.*

*LCDR Bobbi Hovis, NC (Ret.), was in Saigon as the first Navy nurse to volunteer for duty in Vietnam. She had recently helped set up Station Hospital Saigon in a dilapidated Saigon apartment building. This facility provided medical care for U.S. military advisors who more and more were becoming drawn into a vicious civil war.*

It was November 1st, 1963, and the pot had been stirring. The feelings against the Diem government were running higher and higher by the day. There were the pro-Diem faction and the anti-Diem faction. It was the Catholics versus the Buddhists. Diem and his family were Catholic and the [Buddhist] monks were stirring up trouble. You could just sense the tension in Saigon as it was building. You knew something was about to happen.

My senior corpsman, whose name was Paul Burns, went to lunch that day [1 November]. Most of my corpsmen lived in Cholon, which was the Chinese sister city to Vietnamese Saigon. There were a lot of small BEQs [Bachelor Enlisted Quarters] there where our enlisted people lived and they had to go back to their quarters to eat. We had no kitchens at all in the hospital.

Burnie came back and said, "There's all kinds of barbed wire strung across the street. There are gun emplacements set up with .50-caliber machine guns and they're all pointed right up the street at us."

I walked out in the middle of the street and couldn't believe what I



Naval Station Hospital Saigon

saw. I was looking right into the barrels of two .50-caliber machine guns set up in sandbag gun emplacements. "Oh, my goodness," I thought. "What is happening here?" Well, it wasn't very long before the shooting started.

Fortunately, at that time, we had a minimum number of patients in my ICU and it was quiet. I went up to the fifth floor in the hospital on the front

side so I could see better what was going on. I knew that if somebody needed something, Burnie would come up and get me.

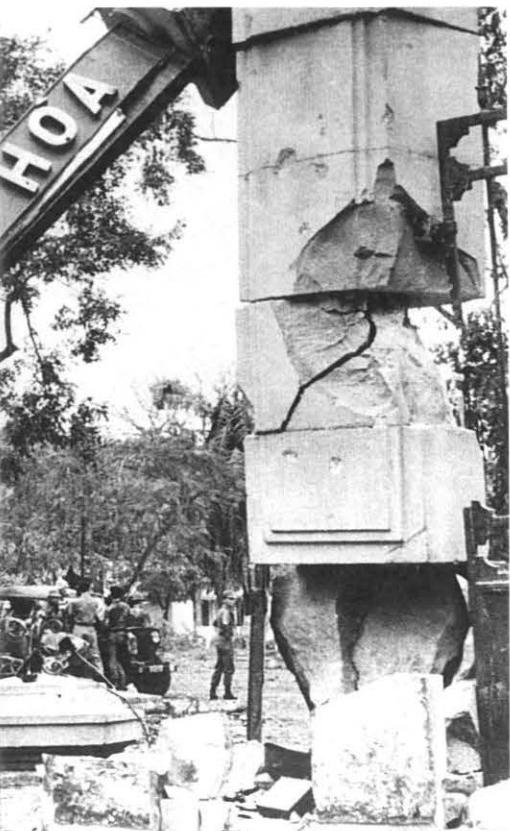
The next thing I knew, bullets were flying in every direction. Three T-28 aircraft being flown by anti-Diem rebels were dive bombing Diem's palace. They were very close. As they released the bombs, anti-aircraft fire



was being returned from the palace roof. An earlier coup attempt in which the palace had been bombed had prompted the installation of those anti-aircraft guns. The next thing I knew, I saw an airplane hit. It went into a dive and disappeared behind some trees.

Meanwhile, the pro-Diem Chief of Naval Operations had been shot at the Naval Station right there on the Saigon River. The fuel farm, also right there on the River at the Vietnamese naval base, blew up and was in flames. Bullets were flying in all directions, and civilians were trying to take cover in the streets. I saw one man shot. A bullet went through the back window of his car, through his chest, and out the windshield. Two men ran out from

Viet Cong terrorists bombed this downtown bar, often frequented by American GI's.



**Left:** Evidence of the battle's ferocity is evident on the grounds of the Presidential Palace. **Below:** Mob rule again prevailed in Saigon's Central Market area just 13 months after Diem's ouster.

a store and dragged him out of the car. I don't know if this man lived or died.

The Civilian National Police were deserting like mad, taking off their uniforms, throwing them down, and running off.

A chief and I were standing on a fifth-floor balcony watching the bombing runs on the palace when suddenly a bullet hit right in front of us on the balcony wall, powdering the stucco. The bullet then ricocheted up from the balcony where it first hit, bounced off the overhead, and fell to the deck. Three inches higher and I would have been hit in my lower chest or abdomen. We both jumped back into the

room and took cover under a table. I still have that .30-caliber bullet. When we didn't hear any more bullets hit, we ventured back out to watch what was going on.

The fighting went on for hours. About 1700, there was a lull and we were transported back from the hospital to our quarters, probably about 3 miles away. We were not receiving casualties at that time.

We barely got back to the quarters when the firing began really in earnest. The quarters were in downtown Saigon and very, very close to Diem's palace. Somebody had set up a 105 mm howitzer out near the Gia Dinh Bridge on the road to Tan Son Nhut airfield. They were firing that howitzer right into the palace. Many of the shells were going astray and hitting all around our BOQ (Bachelor Officers Quarters) and the roofs right near us,





The Station Hospital's operating room

showering us with shards of red roof tile or glass from the next-door building; it was that close. This went on for 18 hours. It got so hot and heavy that I said to the girls, "In case we have to evacuate these quarters, we'd better have a little overnight kit packed, another uniform, and some toilet articles." So we each packed a bag. No sooner had we done so when the firing became even heavier and we took cover.

We lived on the top deck and so I suggested that we go down to the fourth deck and sit in the stairwell which was in dead center of the building. Even though a 105 mm howitzer shell would have gone right through that lightly built stucco, it seemed the safest area in the building.

The next thing we knew, some of the male officers who lived there joined us and we just sat there in the

stairwell. I had my little Zenith Transoceanic radio with me. All we kept hearing on Armed Forces Radio Saigon was normal music while we were in the midst of all this. However, the BBC was relaying what was going on through Manila. That's how we learned of the *coup d'état* that was going on in Saigon. The one thing we

did know was that we were under attack, even though we didn't know who was fighting whom.

It was about then that I decided to keep a journal. I went back up to my room to get a writing pad and a pen. As the coup proceeded and shells were hitting all around, I wrote minute-for-minute.

Eventually, the heavy firing died down and we heard the clank, clank, clank of tank treads. I then went back out onto the seventh floor balcony. I crawled on my stomach so as not to present a target. And I could just peer over the railing and look down. There in the street below I counted 27 tanks mustering right below our quarters. Several hundred fully armed troops accompanied the tanks. We didn't know who these troops were or what faction they belonged to. We certainly didn't know whether they were hostile to Americans.



A quadriplegic patient being prepared for medevac to Clark AFB hospital.



LCDR Hovis poses with a "cracker-box" field ambulance in Station Hospital Saigon's courtyard.

Then everything appeared to come to a halt as they set up the command post below us. I could look right down and hear and see what they were doing. It appeared that they were mustering the troops and the tanks for the final assault on the Diem palace.

Suddenly the tanks began to fire right down the middle of the street. When those cannons fired within the confines of the city, you can't imagine the sound that reverberated off asphalt and brick streets and cement and stucco buildings. It was absolutely deafening. Between the thick cordite and smoke and the deafening blasts and concussion, we all had headaches.

By then we were really fatigued; we hadn't had much to eat and were quite hungry. By now it was November 2nd. About 0400 the tanks and troops started to move out toward the palace. Just at sunrise white flags appeared over the palace even though we couldn't see them. We heard about this on the radio and that the Diem government had surrendered.

I have a remarkable picture of an

L-19 and an DC-3 that flew over town dropping thousands and thousands of colored leaflets to inform the civilian population what was going on, and explain there had been a coup and that the Diem government no longer existed.

There was jubilation in the streets. The people were destroying anything that had to do with Diem. Then they really went crazy. The pro-Diem newspaper office was just within shouting distance of our quarters. The mob went in, got huge rolls of newsprint, set them on fire, and rolled them out in the streets. The fire became very severe and it suddenly seemed ironic that we had lived through this coup only to have our building burn down around us. Then they set fire to a Diem-owned theater, and the pro-Diem police station across the street from us was grenade.

The Diem brothers had made their way through a tunnel out to Cholon, where they took refuge at a Catholic friend's house. But they were hunted down and put into an armored personal carrier, where they were shot and killed.

The fires eventually died down and people started to disperse. They seemed so jubilant as they rode on tanks and APCs [armored personnel carriers]. There was a nice relationship between the soldiers and the civilians, and celebrations broke out throughout Saigon. Jukeboxes were turned on and people began to dance. Dancing hadn't been allowed under the Diems, even though American GIs had taught the young Vietnamese to jitterbug and do the twist.

Finally, about 1000 or 1100 in the morning we went out and walked to the palace. Just walking the five or so blocks, we really saw the destruction. I remember a black Volkswagen that had been parked on the street. It had been hit with so many bullets that it looked like a black piece of lacework. The heavy shelling had knocked down trees and power lines, and the destruction at the Diem palace was incredible.

The palace guards, the elite of the South Vietnamese Army, had been killed or wounded in the coup. What had been their barracks were just holes in building walls—105 mm howitzer-sized holes. There were burned out tanks with bodies still in them, and bloody boots lying around within the palace grounds. The rebels were looting anything valuable.

Life never returned to normal while I was in Vietnam. There was always an undercurrent of unrest from one faction or another. Dissident generals continued to work behind the scenes, planning to stage another coup to overthrow the newly installed Minh government.—JKH



# Basic Hospital Corps School San Diego

**1928-1997**

LT Martha Cutshall, MSC, USN  
LT Sarah Shea, MSC, USN

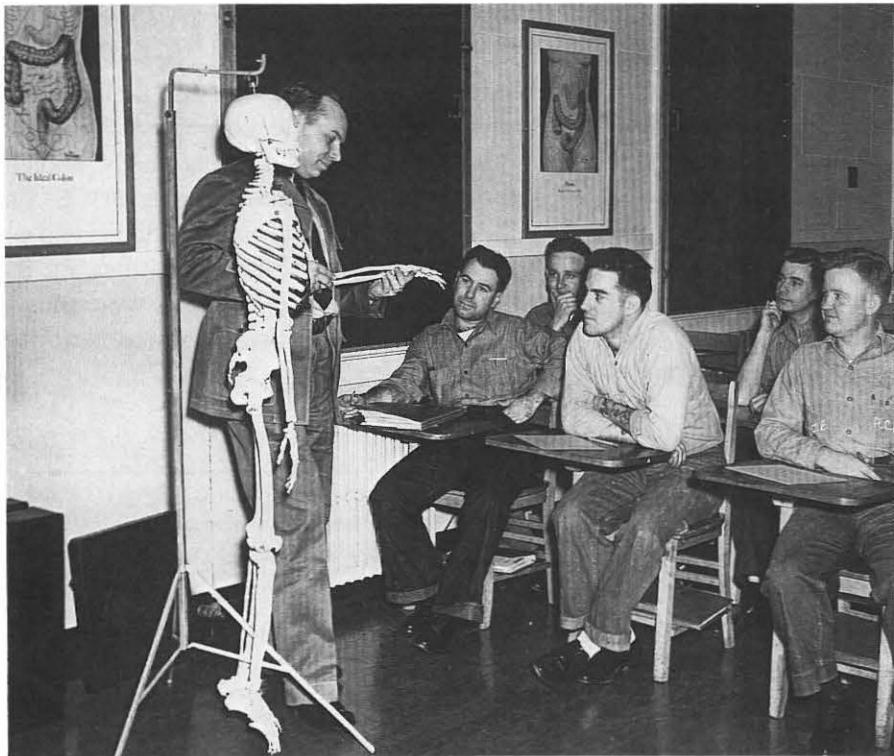
**S**eaman Apprentice Harris will begin to learn his medical ABC's today. Fourteen weeks later Hospital Apprentice Harris graduated from Basic Hospital Corps School (BHCS) at the Naval School of Health Sciences (NSHS), San Diego, CA. He recited the hospital corpsman pledge, sewed his caduceus onto his uniform and went bravely into the future. From that day on, wherever medical services may be required, he will be there, willing and well prepared to provide that medical care and to serve his country and his fellow man.

This story has repeated itself in the hundreds of students who graduated from the Hospital Corps School every year since 1928. However, this story ended on 24 Sept 1997 when the final San Diego BHCS graduating class walked across the stage to get their diplomas. After 69 years in San Diego, the Basic Hospital Corps School at NSHS has closed.

Originally established at the U.S. Naval Hospital San Diego, CA, 1 Sept 1928, the Hospital Corps School trained some 200 students in each 12-week course until April 1932, when insuffi-

cient funding caused the school to be deactivated. On 1 April 1935, it was reactivated and was the only Hospital Corps School in continuous operation since that date.

In 1941 the school had 327 students and a staff of 27 officers and enlisted personnel. Instruction focused on anatomy and physiology, first aid, emergency surgery, bandaging, field hygiene and sanitation, hygiene, preventive medicine, pharmacy, chemistry, nursing, ward management, operating room and surgical techniques, and clerical duties.



*Opposite page:* A nurse trains students at Hospital Corps School, Portsmouth, VA, during World War I. *Left:* During World War II corpsmen receive classroom instruction at Basic Hospital Corps School San Diego. *Below:* Corpsmen learn the techniques of intermittent positive pressure breathing (IPPB) equipment at Basic Hospital Corps School San Diego during the 1950's.



However, the attack on Pearl Harbor and World War II increased the demand for trained hospital corpsmen, so on 9 Jan 1942 the school moved to larger quarters in the hospital compound in Balboa Park to accommodate the daily student load of 1,300. By 1943 a total of 8,918 new hospital corpsmen had matriculated through the school.

As the war continued, the need for trained corpsmen continued to increase and further expansion became necessary. In the spring of 1944, the school again moved, this time to Camp Kidd—a 33-acre area of Balboa Park which had been taken over by the military. The school occupied 10 permanent buildings, 32 temporary buildings equipped as classrooms, and 1 tent section. There was also a commissary, laundry, ship's service, bakery, and barber shop.

The closure of the Hospital Corps School at Great Lakes, IL, in 1944, caused another influx of students to San Diego, and in 1945 the school

reached its peak enrollment with an average student census of 3,400, graduating 14,907 for the year. During this period of increased activity, the staff grew to 18 male officers, 30 Nurse Corps officers, 200 enlisted personnel, and 27 civilians, and the length of the corpsman course was shortened to 4 to 6 weeks.

But San Diego was not the only school training corpsmen for the war effort. Prior to World War II, San Diego was one of only two Hospital Corps Schools, the second located at Portsmouth, VA. By war's end, there were six additional Hospital Corps schools in operation: Bainbridge and Bethesda, MD; Farragut, ID; Great Lakes, IL; and Brooklyn and the Bronx, NY. In all, more than 100,000 corpsmen were trained during the war years.

By 1946, the end of the war and demobilization had reduced the San Diego school's enrollment to about 600, so the school vacated its quarters in Balboa Park and returned to the Naval Hospital compound, and the

Basic Hospital Corps course was lengthened to 16 weeks. Class size continued to decrease and by June 1948, the average daily student census had dropped to 330.

In February 1949, the school became co-ed with implementation of the Women's Appointed for Volunteer Emergency Service (WAVES) program. During the years 1949-1953, 678 WAVES corpsmen were graduated from BHCS San Diego, before the function of training female corpsmen was transferred to the Hospital Corps School in Bainbridge, MD, in 1953.

In the years since 1949, enrollment at the San Diego Basic Hospital Corps School fluctuated widely in response to changing Navy mission requirements. During the Korean conflict and the war in Vietnam, daily enrollment increased to 1,300, dropping to 500 in the postwar years. The length of the school's curriculum also varied, from as little as 4 weeks to as long as 20 weeks.

Responding to the increasing needs of a decentralized military, the NSHS San Diego Detachment, Oakland, CA, was established in 1985 and construction of a new, larger facility in San Diego was begun. On 30 May 1987, staff and students moved into a new NSHS building. The new school had a three-story, 107,000-square-feet building designed by Williamson and Watts of San Diego.

Since July 1974 NSHS consisted of 17 different schools: Basic Hospital Corps, Preventive Medicine Technician, Clinical Nuclear Medicine Technician, Dermatology Technician, Ad-

vanced Medical Laboratory Technician, Ocular Technician, Surgical Technologist School, Otolaryngology Technician, Physical Assistant School, Physical Therapy Technician, Psychiatric Technician, Respiratory Therapy Technician, Basic and Advanced X-ray Technician, Nurse Anesthetist, Physician Assistant, Surface Force Independent Duty Corpsman, and Navy Drug and Alcohol Counselor School. In recent times NSHS San Diego had a daily student enrollment of 750 students, 360 of which were Basic Hospital Corps students.

On 24 Sept 1997, BHCS San Diego graduated its final class. The Basic Hospital Corps School function was relocated and consolidated with its sister school at Great Lakes. Though gone, the contributions BHCS San Diego made to Navy medicine will not be forgotten but will continue into the 21st century through the thousands of dedicated hospital corpsmen who trained there. □

When this article was written LT Cutshall and LT Shea were attached to Basic Hospital Corps School, San Diego, CA.

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# Naval Medical Research and Development Command Highlights

## ●Research Model Streamlines Forward Medical Supplies for the Marine Corps

Recent organizational changes in the medical battalion structure led the Commandant of the Marine Corps to request a review of the current Authorized Medical Allowance Lists (AMALs) for the Marine Corps' far forward medical treatment facilities. Working closely with Marine Corps medical professionals including the 1st, 2nd, and 4th Medical Battalions, the 1st and 2nd Force Service Support Groups, and the Naval Hospitals at Camp Pendleton and Camp Lejeune, researchers at the Naval Health Research Center, San Diego, CA, reviewed treatment briefs, tasks, and supplies and equipment lists. The results of this work is a computer model of echelon I and II (battlefield, battalion aid station, and surgical company) supply streams that establishes a clinical requirement for each item used to support forward medical care. Each clinical requirement is linked to the injuries and diseases known to occur in theater. The researchers first applied the model to laboratory and X-ray supplies and equipment. That study showed that reductions could be made. For example, 39 items in the proposed laboratory equipment AMAL could be eliminated with a corresponding 33 percent reduction in weight and a 16 percent reduction in space. Savings in the weight (55 percent) and cube (71 percent) of the laboratory consumable AMAL also were realized, while increasing the number of diagnostic tests. Reductions were also realized for the two X-ray AMALs. A net weight savings of 19 percent and space savings of 8.5 percent were realized for the proposed equipment AMAL, while a savings of 8 percent in space and 12 percent in weight for the X-ray consumables were realized. Through the process of establishing the clinical requirement for each supply item, an audit trail was produced which, for the first time, gives logisticians and medical planners an objective management tool for maintaining and upgrading medical materiel. To ensure triservice unity, the com-

puter model's data bases are compatible with the DEPMEDS (deployable medical systems) data bases.

## ●Navy Researchers Receive the Inaugural Berry Prize in Federal Medicine

CAPT David M. Harlan, MC, and CAPT Carl June, MC (Ret.), received the Frank Brown Berry Prize for 1997 for their important advances in T-cell manipulation resulting from research at the Naval Medical Research Institute (NMRI), Bethesda, MD. In 1987, while researching new strategies for the treatment of combat injuries, Dr. June and other Navy researchers observed that the engagement of T lymphocytes requires activation of a specific surface receptor on the T cell called CD28. Over the last decade, Dr. June and Dr. Harlan demonstrated that blocking CD28 activation with antibodies and bioengineered molecules prevented T lymphocytes from reacting to foreign protein (or antigen) and rendered them permanently unresponsive (or anergic). This therapy, called anergy therapy, offers a multitude of possibilities for the treatment of combat casualties. Besides the implications for military medicine, anergy therapy has the potential of treating a broad spectrum of medical conditions such as rheumatoid arthritis, insulin dependent diabetes, or systemic lupus erythematosus. This therapy may also have implications for immune reactions such as poison ivy or hay fever. CAPT Harlan is the director of the Immune Cell Biology Program at NMRI, a position which Dr. June held prior to his retirement from the Navy in 1996. Dr. June currently works for the Henry M. Jackson Foundation for the Advancement of Military Medicine. Both researchers are on the faculty of the Uniformed Services University of the Health Sciences. The Frank Brown Berry Prize was initiated this year by *U.S. Medicine*, an independent national newspaper for physicians, with cosponsorship by Science Applications International of La Jolla, CA.

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## Navy Medicine 1944



Bob Hope entertains a sea of Navy nurses.

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